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ABSTRACT

A family therapy model, based on a conceptualization of the family as a behavioral system whose members interact adaptively so that an optimal level of functioning is maintained within the system, is described. The divergent roots of this conceptualization are discussed briefly, as are the treatment approaches based on it. The author's model, Behavior Therapy for Family Systems (BTFS), combines the methodology of behavior therapy with a systems understanding of family interaction. Specifically, it is the organization of a family's problematic interpersonal response patterns into a hierarchy, followed by systematic relearning of appropriate response interchanges. BTFS involves five sets of operations: (1) specifying problem areas of the family system; (2) ranking the problems; (3) outlining the plan of therapy; (4) analyzing problematic response patterns and modeling appropriate alternatives; and (5) rehearsing appropriate response interchanges. All five are discussed in detail. (TL)

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Therapy for Family Systems

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The family therapy model described in this paper is based upon the conceptualization of the family as a behavioral system, whose components (family members) interact adaptively so that an optimal level of functioning is maintained within the system as a whole. This approach, labeled behavior therapy for family systems (BTFS) holds that symptomatic behavior can best be understood according to the function it serves within the system of interpersonal relationships of family members. In essence, the focus of therapeutic behavioral change shifts from the individual alone to other significant forces within his ecosystem as well, most importantly, as his family.

The concept of the family as a behavioral system has roots in the two major theoretical approaches within psychology which have been formulated up to this day: the medical-personality model and learning theory. The basis of the medical-personality model lies in Freud's theory, which emphasized that psychopathology was the result of intra-psychic conflict. Neo-Freudians, such as Alfred Adler, Erich Fromm, Karen Horney, and Harry Stack Sullivan suggested that psychopathology resulted not only from inner tensions within the individual, but from strains in interpersonal relationships formed during the developmental years as well (see Hall & Lindzey, 1957). Although mental health professionals occasionally counseled families or groups, the medical-personality model, emphasizing the patient-therapist relationship, singularly dominated treatment methods until recent years. Within the past two decades, however, research and clinical practice literature began to suggest that psychopathology resulted from social pressures as well as dynamic origins. As a result, clinicians increasingly have

begun to treat "significant others" in the patient's environment as well as the identified agent in order to produce and maintain improved adjustment in the individual (see Haley, 1961).

The "systems" approach to understanding the etiology of psychopathology is an outgrowth primarily of the medical-personality model, although there is a synthesis with some concepts of learning theory. While the medical-personality model assumes that psychopathology is an "inner dysfunction," systems theory espouses that the unit of disturbance is a larger group, embodying many significant agents. Most often, the unit of disturbance is the family, because in most cases, the family is the most important source of impact upon an individual's adjustment. According to systems theory, symptoms (behavior disorder) result from an imbalance of need and need satisfaction among the components of the system (family members). Furthermore, symptoms have an interpersonal communicative function, that is, symptomatic behaviors are designed to influence the relationships among the family members in order to enable each component to achieve a position of relative balance within the system while maintaining optimal functioning of the system as a whole (Haley, 1963; Watzlawick, Beavin, & Jackson, 1967). Thus, drug abuse, alcoholism, school phobias, schizophrenia, obsessive compulsive reaction, and other behavior disorders may be seen as attempts, whether conscious or unconscious, by the symptom-bearer to elicit desired responses from others within his system. Jay Haley, Don Jackson, and Gregory Bateson have been prominent contributors to this line of thinking.

Learning theory rejects the concept of "inner etiology," and instead holds that psychopathology is produced and maintained by contingencies of the environment (Skinner, 1953). This position is espoused by all the prominent present-day approaches to learning which have been formulated: operant conditioning (Skinner, 1938), classical conditioning (Wolpe, 1969), imitation learning (Bandura, 1969), covert reinforcement (Cautela, 1970), rule learning (Miller & Chomsky, 1963) and perceptual learning (Braine, 1963). Psychopathology consists of learned responses which can be modified by re-arranging the contingencies which govern the behavior.

That symptoms are learned behavior patterns is an integral tenet of systems theory. Symptoms represent reciprocal arrangements worked out by two or more people in interaction (Alexander, 1970). A result of this point of view is that the systems approach to understanding behavior and psychopathology focuses on an entire network of relationships.

Treatment Approaches

Most methods of treating families in therapy have been couched in varying degrees in either the medical-personality model or learning theory. Boszormenji-Nagy (Beels & Ferber, 1969), Whitaker (1965), and Wynne (1961) are family therapists whose approach and terminology follow the psychoanalytic tradition. Early applications of learning theory principles in family situations emphasized the modification of one person's behavior, usually a child (see Ullmann & Krasner, 1965). More recently, Johnson and Brown (1969), Patterson, McNeal, Hawkins, and

Phelps (1967) and Safer (1966) systematically reprogrammed operant response patterns of additional family members in order to effect expedient behavior changes in the identified patient. Bach and Wyden (1970), Masters and Johnson (1970), and Stuart (1969) used behavior modification and behavior therapy techniques to alter interaction patterns between marital partners.

Systems theory has been less adaptable to therapeutic applications than either of its parents. Bell (1967), Haley (1963) and Satir (1967) have made formidable attempts to devise practical applications of systems constructs. The product of their endeavors are various strategies of communication intervention; each strategy is complex, difficult to learn and can easily lead to discriminatory coalitions among family members or between certain family members and the therapist (Curry, 1966). Furthermore, while systems theory contributes useful conceptualizations of intrafamilial interaction, it is difficult to operationalize systems principles in practice. Haley (1971), a systems purist himself, has scored a number of deficiencies in systems theory applications to family therapy: (1) the therapeutic procedures are unsystematic; (2) the various procedures have not been empirically validated; and (3) there is little available data from outcome studies to suggest the relative efficacy of various treatment strategies.

Behavior Therapy for Family Systems

BTFS is a systematic approach to family therapy based upon recent research evidence. BTFS provides a way to eliminate most problems

encountered in previous applications of systems constructs to treatment by combining the methodology of behavior therapy (see Lang, 1968; Wolpe, 1969) with a systems understanding of family interaction. Specifically, BTFS is the organization of a family's problematic interpersonal response patterns into a hierarchy, followed by systematic relearning of appropriate response interchanges.

Among recent findings which have highlighted the increasing accumulations of family interaction research, there are two discoveries which provide a basis for the BTFS focus on relearning of response interchanges. These findings are: (1) frequency, direction, and duration of intrafamilial interaction are valid and reliable indicators of family system functioning. Further, the data suggest high rates of unreciprocal interaction among family members (a response of one member which is not followed by a response by another) are significant of family maladjustment (Patterson & Reid, 1968; Rosmann, 1971; Stuart, 1969); (2) modifying response rates in one dyad of the family system can produce predictable changes in response rates of other dyads (Johnson & Brown, 1969; Patterson & Reid, 1968; Rosmann, 1971). These findings suggest that family therapy should be directed toward developing reciprocal response patterns which appropriately satisfy individual and family system reinforcement needs. BTFS concentrates on helping family members broaden their interpersonal response repertoires so that individuals have a variety of adaptive responses available to utilize in solving interpersonal problems, thereby eliminating unreciprocated responses and formation of symptomatic behavior patterns.

The process of translating principles evidenced from family systems research into therapy procedures entails step-by-step ordering of operations, thus making it possible to validate and standardize each procedure with data (as has been done with the technique of systematic desensitization). BTFS involves five sets of operations: (1) specifying problem areas within the family system; (2) ranking the problems according to degree of severity; (3) outlining the plan of therapy with the family; (4) analyzing problematic interpersonal response patterns, selecting and modeling appropriate alternative responses; and (5) rehearsing appropriate response interchanges.

Specifying problem areas. Following the referral, the most conducive approach to obtaining a maximum amount of information and cooperation from the family is to ask all family members to attend at least the initial sessions. Some therapists, however, prefer to exclude younger children at the outset or later in treatment. The initial interview is devoted to assessing problem areas in the family system and dealing with the details of the treatment contract such as the time and place of appointment, fees, who should attend, and requests for information from other sources (e.g., previous treatment references, court records, significant others who may be closely allied to the family system).

The assessment task utilizes a variety of information eliciting techniques, each of which when considered singularly, may have dubious validity and reliability, but which when viewed in a multi-component fashion, have high validity and reliability (Sommerville,

1970). These techniques are: (1) interviewing each family member separately for a few minutes; (2) interviewing the family together; and (3) recording behavioral observations of family process on audio or audio-visual tape so that frequency and duration of responses and the rate of unreciprocated responses can be tabulated later.

Assessment is aimed at helping family members specify problem areas in preparation for more detailed analysis. Often, the presenting symptomatic behavior and family members' complaints are not the key issues which need therapeutic attention. Moreover, individuals may disagree on points. The therapist should be aware that individual family members may want to strike up coalitions and bargains with the therapist (this in itself is useful information), although this danger is partially negated by granting equal opportunity for meeting with the therapist to all members. Lastly, there is one rule the therapist should stress during the initial interview: information not previously known to one or more family members (e.g., an extramarital affair) may not be "used" as a tactic to manipulate other family members outside the consulting office. At the beginning of the next session it is wise to ask each family member if this rule was violated in any way; this measure provides an index of the degree of cooperation the family is willing to make in treatment.

Constructing the problem hierarchy. Organizing a family's problem situations into a hierarchy begins during the first interview, but may take longer. Modifications, revisions and additions often must be made on the hierarchy as more information is obtained during the

progress of treatment. Family members' reports of the impact of various issues are usually discrepant. The number of maladaptive patterns may also vary from family to family. Furthermore, the therapist may be concerned with issues about which the family is unaware or feels differently. The task of obtaining intrafamilial agreement about how to rank various problems is a useful assessment device because the family is thrust into a stimulus situation where they must interact. The experienced therapist can usually detect unreciprocated response patterns by observation alone, but behavioral assessment techniques (i.e., rating responses) yield the most valid data. Constructing the problem hierarchy also has therapeutic value because family members share important feedback about themselves and become more involved in sharing responsibility for each other's behavior.

Issues are ranked from least to most serious along a scale ranging from 0 to 100. An issue of 0 rating would be a situation about which all family members report feeling happy and pleased with one another. For example, a discussion about a mutually satisfying family outing into the mountains might be ranked 0. The most serious problematic issue (e.g., adolescent's drug abuse) is assigned the value 100 and other issues are interspaced between 0 and 100 according to the weight the family assigns them. A sample hierarchy for a three-member family is presented below:

1. Family visit to the zoo.
2. Parents' debate over what to give child for his birthday.
3. Child not coming home immediately after school.
4. Mother not keeping up the house.
5. Child's poor school grades.

6. Child not attending Church with parents.
7. Mother and father's heated arguments about money.
8. Father's heavy drinking.
9. Child's frequent running-away from home.

Outlining the plan of therapy. Frequently, not all family members see themselves involved in the pathological behavior of another member. To be aware of their involvement would constitute a breakdown in the functionality of the symptomatic behavior. On the other hand, other families and family members may feel extremely guilty about their behavior (e.g., a mother feeling that she has failed because her child committed a criminal act). It is important for members of a family to realize that the responsibility for disordered behavior does not reside only in individuals, but within the entire family system. Once the family members learn this concept, learning new response patterns becomes much easier because family members are more aware of the contingencies which control their behavior. Furthermore, this education about their behavior often helps family members establish a more objective attitude toward each other's behavior.

In order to help family members understand how they behave in response to other members' behavior, it is helpful to use concrete examples. Consider the following illustration:

> Brad, a 12 yr. old boy, is the only child of an industrious, socially respected but unhappily married couple. The father is a sales manager who travels a great deal and the mother is busily involved in community projects, clubs and church organizations. Brad's bids for parental attention usually are met with little or no response because of his parents' busy schedules. Consequently, he has begun to run around with a group of troublesome young fellows whose misdemeanors continually result in notoreity. In this case, Brad's delinquent behavior is symptomatic of a maladjusted

> family system, yet his behavior is functional. Brad's acting-out usually obtains parental attention, negative though it may be. At the same time, the mother and father "use" Brad as a lever to blame each other as a parental failure.

Treatment is directed largely toward reeducating the family; first, by explaining how family members have acquired their maladaptive response patterns and secondly, by developing appropriate alternative response patterns. It is expedient that educating the family about their behavior and explaining therapeutic procedures take place as early in the treatment process as possible.

Analysis of response patterns and development of appropriate responses. Treatment proceeds by closely analyzing with the family the intrafamilial response patterns of each problematic situation, beginning with the least troublesome issue and working up the hierarchy. Analysis of problematic response patterns is a cooperative venture between the therapist and family members. Family members are encouraged to adopt an objective stance toward each other and try to identify what each person wants to attain concerning the issue under discussion. Asking each family member for information helps produce an objective atmosphere and enlists each person as a participant in the decision-making endeavors.

Having identified each person's 'wants" concerning an issue, the next step is to devise ways of satisfying individual needs without greatly disturbing family system homeostasis. The therapist encourages family members to make overtures among themselves in order to open negotiations (e.g., "What do you think? What will you do if I do that?").

Because individuals frequently are "entrenched" in polar positions concerning an issue and feel a great personal investment in maintaining that position, it is often difficult to maneuver family members to begin negotiations. Therapist modeling of overtures and demonstration skits with family members usually facilitate collective bargaining.

The guiding principle for collective bargaining is that the resolution should have reciprocal benefits for the involved parties. To illustrate, consider once again the case of Brad's delinquency. A suitable resolution might entail Brad's agreement to associate less with his troublesome peers if his parents agree to buy him fishing tackle and go on family fishing trips regularly. In this case, all the family members stand to benefit from the agreement. In cases where some family members are not directly involved in the contract, they should act as referees to remind the involved parties of their responsibility and to judge if the terms of the bargain were fulfilled, thus retaining their involvement in the family interaction.

Sometimes, the collective bargaining process may involve complex reciprocal arrangements entailing many ramifications. At times also, issues may need to be renegotiated when the resolution falls flat or the issue reappears in another form. Usually two or three bargains concerning one or more issues can be worked out in each session. Reports should be collected on a continuing basis in sessions thereafter. When the family agrees that they have completely resolved an issue, attention can be focused on the next higher issue on the problem

hierarchy. Mutually satisfying resolution of small issues lends confidence that more serious issues can also be solved. Learning how to handle small interpersonal problems generalizes to problems with higher severity rankings.

Rehearsing response interchanges. In order to facilitate generalization of newly learned adaptive response patterns to situations where the therapist is not present, it helps to rehearse response interchanges in the consulting office. Family members may feel embarrassed about practicing collective bargaining in the therapist's presence, but with encouragement they often will enter into enthusiastic dialogue. Feedback from the therapist enables the family to clearly discriminate characteristics of constructive response interchanges. Most often, families learn quickly after one or two issues have been rehearsed.

The rehearsal process also provides the therapist with an opportunity to rate the frequency and duration of responses and to tabulate unreciprocated responses. Comparison of behavior ratings with family members' self reports gives a good index of therapeutic progress.

Record keeping. Keeping accurate records of the issues and bargains, and maintaining periodic rating measures provide a systematic method of evaluating progress and also allow validation of the BTFS technique. The author uses tally sheets (see Appendix A) to record reports given at the beginning of each session and to list bargains made during sessions. Lastly, the family is asked periodically (every

few sessions) to evaluate resolved issues and to collectively re-rate the severity of the issues. This procedure serves as an additional check on the progress of therapy. If issues continue to manifest interpersonal discomfort, they are dealt with in treatment until the issue is effectively resolved.

Summary Comments

The family therapy model described in this paper is based upon conceptualization of the family as a behavioral system, whose components (family members) interact in a fashion which maximizes the satisfaction of individual reinforcement needs, while at the same time maintaining homeostatic functioning of the family system as a whole. According to this model, symptomatic behavior is seen as disharmonious adjustment between the disordered individual's need satisfaction and the reinforcement needs of the family system.

Recent findings from family system research suggest that therapeutic intervention in maladjusted family systems should be directed toward developing reciprocal interpersonal response patterns which appropriately satisfy individual and family system reinforcement deficits. BTFS is a series of procedures for therapeutic intervention which combines the methodology of systematic behavior therapy with a systems understanding of family interaction. BTFS involves working out mutually beneficial arrangements among family members concerning problematic issues.

A promising feature of BTFS is its systematic approach, which allows for evaluation of therapeutic progress and validation of the technique. Presently, BTFS is in the beginning stages of validation and much more research needs to be done. Outcome studies and research with normal families making benign changes may provide helpful data.

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Appendix A

BTFS Record Sheet

Name: Therapist:

Date	Issue and Rating	Resolutions	Results and Followup Ratings